

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED SEP 20 1948

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

State File No.

Registrar's No.

30929
7865

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Mildred M. Croak

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Wm. H. Croak 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept. 3 1893
(Month) (Day) (Year)

8. AGE: Years 55 Months 0 Days 3 If less than one day
hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. MacCash
13. Birthplace Scotland
(City, town, or county) (State or foreign country)
14. Maiden name Eleanor Spraggon
15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Eleanor Dollar
(b) Address 4775 Greer Ave.

17. (a) burial (b) Date thereof 9-9-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge Blvd.

19. (a) SEP 7 1948 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 009
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6 4956a Aldine Place
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6
year 1948 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from 8-19-48
to 9-6-48, 1948.
that I last saw her alive on 9-6-48, 1948.
and that death occurred on the date and hour stated above.

Immediate cause of death
respiratory failure
Due to cerebral thrombosis

Due to hypertensive heart disease
Other conditions (Include pregnancy within 3 months of death) 92

Major findings: Of operations _____
Of autopsy thrombosis of basilar artery

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury U
23. Signature Arnold Daneker (M. D. or other) M.D.
Address St. Louis Jewish Hosp. Date signed 9-7-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

True

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.